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## Guest editorial

# Markets and ethics

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It is more than ten years since we were encouraged to think of the National Health Service in market economy terms. This conceptual move was due to the deliberate introduction by the government of free market economy ideology to the health service. On any analysis the health service was in need of reform but, arguably, it should be possible to have a cost-effective and efficient health service without the inclusion of the purchaser-provider split and GP fund-holding, the main planks of the internal market system. The arrival of the internal market led to a number of changes, some of them subtle, in the way in which we think about the health service. A change in the culture of health care has come about and the language of competition has nudged aside the more established discourse which embodied Hippocratic notions of duty and professional altruism.

Health care professionals have to varying degrees accepted the market culture, but at some cost. It has become a commonplace for commentators on the state of the health service and the performance of the professionals working within it to adopt the language and ideology of the free market. Research into the utility of health care practice quite reasonably includes notions of cost effectiveness and a consideration of resources. The public, though, has not responded well to the behaviour of some professionals in the new look health service. For example, there was an expression of outrage in the press when earlier this year the Royal College of Nursing (RCN) voted to rewrite its no strike clause in response to the Pay Review Body's recommendation of a three per cent award (a figure lower than the rate of inflation) whilst other sectors were gaining rather better settlements. The issue was complicated by the suggestion that only one per cent should be nationally funded and the rest negotiated locally.

The apparent public displeasure with nurses was expressed in headlines of the 'tainted angels' variety. The RCN had rewritten their rule 12 in such a way that the college members could take industrial action. The press did not trouble to make it clear that the college's fundamental position forbidding any action which would harm patients remained unchanged. The surprised tones adopted by the media stemmed,

perhaps, from the disruption of the longstanding favourable image that society has of nurses and the nursing profession – a disruption brought about by the idea of nurses in the royal college contemplating strike action. Despite the fact that some nursing unions have in the past taken industrial action, the public cling to the notion that mainstream nursing morality is enshrined in the practices and statements of its royal college. This image of nursing has allowed the public and governments alike to assume that nurses will continue to give excellent service under whatever conditions are put their way.

It is widely recognised that there was room for reform in the NHS and that such a large-scale publicly funded enterprise must be called to account for its practices and expenditure. Nursing absorbs a large proportion of the health care budget and comprises a large and well-organised occupational group within the health service and has to be reckoned with. The problem highlighted by this year's nursing pay dispute goes well beyond the issue of three per cent, and local bargaining. These were merely indicators of a deeper trouble which has to do with the struggle between the authority of the NHS and the power of the health professions.

The Department of Health draws its authority from the fact that it is acting on behalf of the electorate and has secured its budget through the annual scrap that is the public spending round. The authority of the health care professionals, however, stems from the trust that society has placed in its professions, requiring them to act in the interests of all patients. Professionals in health care, whilst they are contracted to work by the National Health Service, draw their authority in clinical matters from their peers, organised through professional associations. There are problems inherent in arrangements where professionals work within bureaucratic organisations. Tensions exist between the power of the organisation and the power which resides in the wider professional group. In this nurses' pay dispute we saw the power of the government set against that of the RCN, nursing's leading professional body.

Nurses and other health care professionals do not work solely from a position of disinterested altruism,

they have a living to make just like everyone else, therefore negotiation of salary and conditions of employment is to be expected. However, the public, if the media portrayal was correct, did not approve of nurses adopting the tactics of the market place. The problems that nurses encountered with the media representation of their case stems from the fact that the ethical stand which they were trying to adopt could easily look like a simple matter of self-interested pay bargaining. Likewise, the media missed the ethical aspect of clinical decisions in recent articles about perceived misuse of power by doctors when it comes to decisions whether to treat or not. Complex medical decisions taken on clinical and ethical grounds have been portrayed in the press in simple cost terms and this undermines the autonomy of the medical profession by calling professional judgment into question.

Nurses' concern with the breakdown of national pay bargaining and the introduction of local agreements had less to do with pay and more to do with a desire that there should be the same standard of service across the country within a national system of health care. Local pay bargaining could be said to be in keeping with that aim, following Aristotle's notion of treating equals equally and the unequal unequally in proportion to their (morally relevant) inequality. The RCN drew attention to the downside of local negotiations, namely the weakening and de-stabilisation of professional associations. Professionals, through their peer group organisations, maintain the standards of their practice. Self-regulation of the professions need not be linked to issues of pay and conditions, yet it has to be recognised that a coupling of the two functions is one way of strengthening the power of the professional group. Local pay bargaining which can be said to undermine the power of the professions is resisted by professional associations. One very reasonable ground for this resistance is the argument that professions are a national and not a local resource therefore a strong national (or indeed international) professional organisation is ultimately a good thing for society. Professional power brings with it the potential for self-regulation and the preservation of the notion of professional duty which is in the public interest. Freedom of practice of health care professionals clearly cannot go unchecked, but the market culture has perhaps shifted the balance too far and society, whilst it may be protected from the

power of the professions, could be deprived of their wisdom.

Leaving the professions to do their own thing is not as simple as believing that 'a happy work force makes for happy patients', but there could be a grain of truth in that adage. The tension between governments and professions raises questions about who is running the health service and upon what set of principles. Ever since the Griffiths Report was published in 1983 the now tired comparison between providing the nation with health care as opposed to baked beans has been made. With the Griffiths reforms the government's belief in market forces was imposed on the health service without taking account of two factors which make the workings of the market in health care problematic, namely that it is a managed internal market and that the customer is not, as is usually the case, the ultimate consumer.

The shift to the internal market culture in the NHS has produced a tendency for the major discussions about the workings, and indeed the future, of the health service to be held within a rather different discourse from the one which has previously prevailed. It is ironic that at a time when an interest in business ethics (this is no longer thought of as an oxymoron) is on the rise in the world of commerce and related academic departments, the government introduces the business ideology into the health service. As ethical concerns gain ground in business circles in the health service they are in danger of being replaced by the new-found preoccupation with the internal market and cost-driven decisions. The issue is about the move from a discourse based on moral considerations and ethical principles to one which has become so market-driven that other perspectives have been overshadowed. Undoubtedly there are links to be made between cost, quality and a health service which is clearly guided by moral principles. Money well spent, following the principles of distributive justice, cannot be against the notion of good health care practice. However, it may yet turn out to be the case that the introduction of the internal market has had more influence on the nature of ethical debate in health care than it has on the organisation of the service.

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